

CSCT Work Group Committee  
April 20, 2005

Members Present: Drew Uecker, Carol Ewen, Candy Lubansky, Doug Sullivan, Jody Martz (for Jim Parker), Susan Bailey-Anderson, Bob Runkel, Diane White, Duane Preshinger, Michelle Gillespie, and Sara Loewen.

Duane has some concerns with the rule at it is. He feels that taking out the 12 child limit leaves the program wide open. There is nothing to prevent a program from putting in 24 kids. He questions whether they would still be getting CSCT services if this happened?

Diane commented that this may lead to less than altruistic means.

Bob asked if the 720-unit limit without the cap on the number of kids that was presented at the public meeting. Michelle confirmed that it was.

Carol commented that if a program was going to provide a good set of services, that you can't have that many kids. The school recommends the high needs kids who especially need the services. Schools are also able to monitor or police what goes on with the services that are being provided.

Diane wondered if schools were or might make recommendations for kids who were not identified at SED, possibly pushing the CBPRS aide.

Drew brought up the question of a minimum number of kids in order to have a program. For instance, if they are currently serving 18 kids, can/or should they split it up into two programs. They could have 12 & 6 or 9 & 9 and each program is able to bill the total 720 units. Drew wants some kind of safeguards built in order to keep the program viable. There was some discussion about this point.

Carol remarked that if they pull kids out too much, they hear about it from the teachers. There are only certain times that they want the student gone from the classroom. There has to be a partnership between the program staff and the staff

Duane commented that we should have some general guidelines that can guarantee the program is providing medically necessary services and reduce the chances of the department having to come back and take money back from the schools.

Bob is uncomfortable with changing this from what was presented at the public forum. He is not sure if putting a cap on the number of kids will guarantee quality assurance. The only thing it may accomplish is limiting services. If we are interested in quality assurance, we have put in the additional requirements for staff training, school involvement, and outcome measures.

Carol remarked that no matter what you put in, in regards to limits, there will be someone who tries to get around it. We have tried to establish a program based on best practices instead of built on how to limit services.

Duane wondered if adding more of the quality control burden to the schools will be helpful, or will they just say they don't want it and dump the whole program.

Carol replied that outcome measures were included as quality assurance/control . This is a better measurement of services, than the number of hours billed. Could the State provide some training to MHC and schools about Medicaid billing?

Doug commented that he does have a problem with adding a cap, that may say how many hours a child should get. Kids have to be qualified with the SED label in order to receive services. The hours should be determined at the CST/IEP meetings, or treatment team meetings. He does want to guarantee the integrity of the program so that we don't lose it.

Candy liked the idea of DPHHS providing training to the schools about medical necessity and monitoring of the program so that it meets the children's needs.

Bob asked about the possibility of setting up this training through METNET to coincide with all the new regulations that will be coming out September 1.

Duane said that he doesn't want the department to be set up to be the bad guy because we will have to be the ones to take the money back if it comes to that. He wants to avoid that from the beginning.

Candy asked if there was a way to give an "at risk" notification about billing problems that are occurring, instead of waiting until the audit comes through. There was some discussion about the amount of time it takes for claims to process. Sending out a notification, isn't feasible, because of this. It was advised that schools do spot checks of the MHC's claims, or check in with them if they have had denied claims. The availability of training was brought up again.

Bob suggested that we have some way to examine concerns about numbers of kids in the program, whether there are too few or too many, and the associated billing errors. Then we can go back and add parameters and endpoints. We can look at the data for the previous year, after the new ARM comes out. Right now

there has been a terrible lack of understanding of how the program works. Hopefully with the new ARM and language for the RFP we will have a program based on quality instead of funding.

Duane agreed to not add a cap on the number of kids served at this time. He does want to make sure that schools are aware of their liability with the billing. Re-evaluating the program again in a year, after the 720 unit limit has been in place is a good idea.

Diane added some of the black and white measurable data from the CSCT language/rule to the MHC rule. This did not change the CSCT rule, but added the corresponding language to the MHC rule. She will be filing this at the same time as the CSCT rule (by May 29<sup>th</sup>). She also added a Prior Authorization requirement for receiving duplication of outpatient and CSCT services.

Bob suggested adding the following subsection to the Mental Health rule 37.106.1919:

d) for each MHC providing CSCT services, a quarterly review of the effectiveness of CSCT services, financial status, staffing patterns and staff caseload with the school district administration or designee.

Hopefully this will help the school district monitor the caseload and billing practices. Everyone agreed to add this statement to the rule.

Certification of match was brought up. Bob questioned whether or not there was a way to build a structure that "sorts" kids if they receive CSCT services under an IEP (where OPI meets the match) and those not under an IEP (where the school has to meet the match).

Michelle said that the only way to separate these would be at the end of the year when they send out the forms for the certification of match. There really isn't any way to keep a running total during the year.

Doug commented that his clerk thought this years form was much more time consuming to come up with the data for the certification of match.

Michelle agreed there was more work because the department needed to collect more data this year in order to establish the rate. Last year's certification of match was a check-off of how the school met match and no cost data was requested. Hopefully, next year will be better.

There was a short discussion about the Refinancing Project and the addition of services, specifically mental health related. Everyone agreed that services would be limited to only those in Special Education and identified under an IEP. There

are too many challenges when the services are not specifically identified under the IEP.

Behavioral Specialists or one-on-one aides were suggested. There is a demonstrated medical necessity for this service. This may also be a good option for schools that don't have access to CSCT services. Autism is in the SED definition (for right now). There are a fair number of ED kids that could benefit from this also.

Candy commented that in Minnesota, Medicaid descriptions were very specific about what the behavioral specialist activities could be and the services that were covered (prescriptive and diagnostic). These were mostly based on the activity of the child and the function of the child in the school.

These ideas will be given to Jeff Harrison from the Office of Planning, Coordination and Analysis. Jeff will be at our next meeting to discuss these and any other ideas.

The next meeting will be June 29, from 11:00 to 2:00 at 111 North Sanders, room 207.